STATE OF TENNESSEE

DEPARTMENT OF COMMERCE AND INSURANCE

TENNCARE DIVISION

and

THE OFFICE OF THE COMPTROLLER OF THE TREASURY

DIVISION OF STATE AUDIT

MARKET CONDUCT EXAMINATION

and

LIMITED SCOPE FINANCIAL AND COMPLIANCE EXAMINATION

OF

PREMIER BEHAVIORAL SYSTEMS OF TENNESSEE, LLC

NASHVILLE, TENNESSEE

FOR THE PERIOD JANUARY 1, 2006
THROUGH JUNE 30, 2006

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DATE: May 30, 2007

The examination fieldwork for a Limited Scope Financial and Compliance Examination and Claims Processing Market Conduct Examination of Premier Behavioral Systems of Tennessee, LLC, Nashville, Tennessee, was completed December 1, 2006. The report of this examination is herein respectfully submitted.

I. FOREWORD

This report reflects the results of a market conduct examination "by test" of the claims processing system of Premier Behavioral Systems of Tennessee, LLC, (Premier). Further, this report reflects the results of a limited scope examination of the financial statement account balances as reported by Premier. This report also reflects the results of a compliance examination of Premier's policies and procedures regarding statutory and contractual requirements. A description of the specific tests applied is set forth in the body of this report and the results of those tests are included herein.

II. PURPOSE AND SCOPE

A. Authority

This examination was conducted jointly by the TennCare Division of the Tennessee Department of Commerce and Insurance (TDCI) and the Office of the Comptroller of the Treasury, Division of State Audit (Comptroller), under the authorization of Section 3.12.19 of the TennCare Partners Provider Risk contract between the State of Tennessee and Premier and Tennessee Code Annotated Sections 56-51-132, 56-32-215, and 56-32-232.

Premier is licensed as a prepaid limited health services organization (PLHSO) in the state and participates by contract with the state as a behavioral health organization (BHO) in the TennCare Partners Program. The Tennessee Department of Mental Health and Developmental Disabilities (TDMHDD) is responsible for administration of the TennCare Partners Program. TDMHDD and the Bureau of TennCare are responsible for verifying the eligibility of participants and for assigning them to and disenrolling them from the TennCare Partners Program.

B. Areas Examined and Period Covered

The market conduct examination focused on the claims processing functions and performance of Premier. The testing included an examination of internal controls surrounding claims adjudication, claims processing system data integrity, notification of claims disposition to providers and enrollees, and payments to providers.

The limited scope financial examination focused on selected balance sheet accounts and the TennCare income statements as reported by Premier on its National Association of Insurance Commissioners (NAIC) quarterly statement

for the period ended June 30, 2006, and the Medical Loss Ratio Report for the period ended June 30, 2006.

The limited scope compliance examination focused on Premier's provider appeals procedures, provider agreements and subcontracts, the demonstration of compliance with non-discrimination reporting requirements and the Insurance Holding Company Act.

Fieldwork was performed using records provided by Premier before, during, and after the onsite examination, at the Nashville, Tennessee, office from September 5, 2006, through December 1, 2006.

C. Purpose and Objective

The purpose of the examination was to obtain reasonable assurance that Premier's TennCare operations were administered in accordance with the Provider Risk Agreement, and state statutes and regulations concerning PLHSO operations, thus reasonably assuring that the Premier TennCare members received uninterrupted delivery of mental health and substance abuse services on an ongoing basis.

The objectives of the examination were to:

- Determine whether Premier met certain contractual obligations under the Provider Risk Agreement and whether Premier was in compliance with the regulatory requirements for PLHSOs set forth in Tenn. Code Ann. § 56-51-101 *et seq.* and Tenn. Code Ann. § 56-11-201 *et seq.*;

- Determine whether Premier had sufficient financial capital and surplus to ensure the uninterrupted delivery of mental health and substance abuse services for its members on an ongoing basis;

- Determine whether Premier properly adjudicated claims from service providers and made payments to providers in a timely manner;

- Determine whether Premier had implemented an appeal system to reasonably resolve appeals from TennCare providers in a timely manner, and

- Determine whether Premier had corrected deficiencies outlined in prior examinations by the Comptroller or TDCI.

III. PROFILE

A. Administrative Organization of Premier

Premier Behavioral Systems of Tennessee, LLC, was organized in May 1996 and owned by Premier Holdings, Inc., a wholly-owned subsidiary of Magellan Health Services (Magellan), and Columbia Behavioral Health, LLC, ultimately a wholly-owned subsidiary of HCA, Inc., for the purpose of contracting with the State of Tennessee Department of Mental Health and Developmental Disabilities (TDMHDD) to deliver mental health and substance abuse services to the TennCare Partners Program. On January 5, 2004, Onex Corporation, Toronto, Canada, acquired a 24% ownership interest in Magellan and became the ultimate controlling entity. In 2005, in two separate transactions, Onex sold of all the shares of common stock it held in Magellan and no longer holds an interest in the company. On April 11, 2006, Premier Holdings, Inc., purchased Columbia Behavioral Health, LLC's 50% ownership interest in Premier making Premier a single member limited liability company.

Premier contracts with AdvoCare of Tennessee, Inc., also a wholly-owned subsidiary of Magellan, to manage the operations, administrative services and clinical services related to provision of all mental health benefits, to provide case management services and to arrange primary care and outpatient services.

The officer and board of directors for Premier at June 30, 2006, were as follows:

Officer for Premier

Russell C Petrella, President

Board of Directors for Premier

William Grimm Russell Petrella Rene Lerer

B. Overview

The TennCare Partners Program, a managed care capitation program for mental health and substance abuse services, was initiated on July 1, 1996, and is designed to function in a manner similar to the TennCare Program. TennCare replaced the existing Medicaid Program on January 1, 1994, with a

program of managed health care providing traditional medical services. Prior to July 1, 1996, mental health and substance abuse services were generally funded by grants or fee-for-service payments from the state. Although some grant payments, such as those grant payments made by the Department of Children's Services to the community mental health centers, are unaffected by the TennCare Partners Program, funding for most of the services has shifted to the TennCare Partners Program. Each month, the state pays a capitation rate for each TennCare Partners Program participant to one of the two managed care organizations, referred to as behavioral health organizations, that contract with the state to provide mental health and substance abuse services. The BHOs are Premier and Tennessee Behavioral Health, Inc. (TBH).

Premier is licensed and regulated by TDCI as a PLHSO pursuant to Tenn. Code Ann. § 56-51-101 *et seq.* TDCI issued Premier a certificate of authority to operate as a PLHSO on November 19, 2003.

The assignment of TennCare Partners Program participants to the two BHOs is based upon the participants' enrollment in the TennCare managed care organizations. There were approximately 595,300 Premier participants as of June 30, 2006. During the examination period, the managed care organizations and their participants assigned to Premier were as follows:

- Volunteer State Health Plan, Inc. d/b/a BlueCare and TennCare Select*
- Unison Health Plan of Tennessee, Inc.
- UAHC Health Plan of Tennessee, Inc.
- Windsor Health Plan, Inc.

* The children in the Department of Children's Services custody and out-of-state enrollees receiving services in the East Tennessee region remain assigned to Premier.

The remaining managed care organizations' enrollments, approximately 594,700 participants, were assigned to TBH as of June 30, 2006.

There are two categories of participants in the TennCare Partners Program: priority participants and basic participants. Priority participants include individuals diagnosed as severely and/or persistently mentally ill (SPMI) aged 18 years or older and individuals under the age of 18 diagnosed as having severe emotional disturbance (SED). TennCare Partners participants who are not priority participants are referred to as basic participants. Services covered for both the priority and basic participants include inpatient psychiatric hospitalization, outpatient mental health services, substance abuse treatment,

psychiatric pharmacy and lab-related services, transportation to mental health and substance abuse services, and specialized crisis services. Additional services covered for the priority population includes mental health case management, 24-hour residential treatment, housing/residential care, specialized outpatient and symptom management, and psychiatric rehabilitation services.

An additional category of individuals for which mental health and substance abuse services are covered by the BHOs is judicials. These individuals are not considered enrollees or participants in the BHO plan but are entitled to coverage for services required by the statute or court order under which the individual was referred.

C. Provider Contracts and Subcontracts

The contract between TDMHDD and Premier requires Premier maintain a sufficient inpatient network, so no inpatient provider, especially the regional mental health institutes, is forced to exceed licensed capacity. Premier contracts with the State of Tennessee's five regional mental health institutes. These institutes provide essential inpatient mental health services to the priority population. Premier has contracted with the regional mental health institutes on a per diem basis. Inpatient, intensive outpatient, and partial hospitalization services are also provided by hospitals across Tennessee on a per diem basis.

In addition, the contract encourages Premier to contract with community mental health centers (CMHCs). The primary providers of outpatient mental health services for the priority population are the CMHCs located across the state. The CMHCs act as care coordinators responsible for arranging the behavioral health care needs of their assigned participants. Premier compensates the CMHCs with monthly case rate payments per SPMI participant. The case rate payment is based on tiered levels determined by the average number of case management encounters the CMHC provides. The CMHC case rate payments are adjudicated through an internal claims processing system developed by AdvoCare. The 24 CMHCs send AdvoCare monthly electronic files that contain the claims information that is required on a standard physician medical claim form. AdvoCare sends interim monthly payments to the CMHCs which are ultimately reconciled to adjudicated claims data.

Other providers, including physicians, psychiatrists, licensed social workers, and hospitals, are paid through a subcontracted claim processor based upon a fee schedule or per diem. During the period under examination, Magellan

subcontracted with Affiliated Computer Services, Inc. (ACS) for processing and paying claims submitted by providers with the exception of CMHC providers.

Effective July 1, 1998, the state assumed financial responsibility for the cost of all behavioral health pharmacy services to TennCare enrollees in the TennCare Partners Program.

IV. PREVIOUS EXAMINATION FINDINGS

The previous examination findings are set forth for informational purposes. The following were financial and claims processing deficiencies cited in the examination by the Comptroller of the Treasury, Division of State Audit, and the Tennessee Department of Commerce and Insurance, TennCare Division, for the period January 1, 2004, through June 30, 2004:

A. Financial

1. Premier should improve the methodology utilized for the allocation of management fees to expense categories on the NAIC financial statements by initially identifying salaries and compensation incurred by the management company which are 100% related to Premier or other affiliates. Salaries and compensation that are related 100% to a plan should be allocated to the specific plan before other pertinent ratios are applied. Any change to the methodology will not affect reported net income or net worth but the improved methodology will provide a more accurate representation of administrative expense on NAIC financial statements.

The deficiency listed above is not repeated as part of this report.

B. Claims Processing System

1. The April 2004 claims data file submitted by Premier for TDCI to test prompt pay requirements erroneously included a behavioral health claim that was paid by TBH.

2. The sampling methods to determine the claims payment accuracy percentages reported by Premier to TDMHDD were inadequate. Premier failed to include in the test population all claims processed by Premier and the claims processing subcontractor.

3. From the 30 fee-for-service claims selected for testing, two claims had keying errors of information reported on the hard copy claim.

4. One fee-for-service claim was denied incorrectly by Premier for the denial reasons of member was not on file and the date of birth could not be matched.

5. Premier does not load copayment accumulator files from the TennCare Bureau into their claims processing system. Without the consideration of the copayment accumulators from TennCare, Premier could continue to apply copays even if an enrollee had exceeded his/her annual out-of-pocket maximum.

None of the deficiencies listed above are repeated as part of this report.

C. Compliance Testing

1. Premier did not provide written policies and procedures to process provider complaints.

2. One provider complaint tested was not responded to within the 30 day standard utilized by Premier.

3. For two provider complaints tested, the response date reported on the complaint log did not agree with the response date on the supporting documentation.

4. The subcontract between Magellan and ACS for claims processing is non-compliant at the report date due to changes in the subcontract requirements of the TennCare Partners Provider Risk Agreement.

5. Premier did not submit to TDCI, for required prior approval, the service agreements which represent a material modification to Premier's application for certificate of authority pursuant to Tenn. Code Ann. § 56-51-108.

Deficiencies number 4 and 5 above are repeated as part of this report. The other deficiencies noted above were corrected and thus not repeated in this report.

V. SUMMARY OF CURRENT FINDINGS

The summaries of current factual findings are set forth below. The details of testing as well as management's comment to each finding can be found in Sections VI, VII and VIII of this examination report.

A. Financial Analysis

There were no deficiencies discovered during the limited scope financial examination for the period January 1, 2006 through June 30, 2006.

B. Claims Processing System

There were no deficiencies discovered during the claims processing examination for the period January 1, 2006 through June 30, 2006.

C. Compliance Testing

1. Premier modified a provider agreement without obtaining prior approval by TDCI as required by Tenn. Code Ann. § 56-51-108. (See Section VIII.C.)

2. Premier should correct previously noted language deficiencies in a subcontract template with Community Service Agencies. (See Section VIII.D.)

VI. DETAIL OF TESTS CONDUCTED – FINANCIAL ANALYSIS

A. Financial Analysis

Premier is required to file annual and quarterly financial statements in accordance with NAIC and statutory guidelines with the Tennessee Department of Commerce and Insurance. The department uses the information filed in these reports to determine if Premier meets the minimum requirement for statutory reserves. The statements are filed on a statutory basis of accounting. Statutory accounting differs from generally accepted accounting principles because "admitted" assets must be easily convertible to cash, if necessary, to pay outstanding claims. "Non-admitted" assets such as furniture, equipment, and prepaid expenses are not included in the determination of plan assets and should not be considered when calculating capital and surplus.

At June 30, 2006, Premier reported $50,430,018 in admitted assets, $34,891,482 in liabilities and $15,538,536 in capital and surplus on its NAIC statement. Premier reported net income of $6,771,468 on its statement of revenue and expenses as of June 30, 2006.

1. Capital and Surplus

Tenn. Code Ann. § 56-51-136 requires a PLHSO to establish and maintain statutory financial reserves as calculated pursuant to Tenn. Code Ann. § 56-32-212.

Tenn. Code Ann. § 56-32-212(a)(2) includes in the definition of premium revenue "any and all payments made by the state to any entity providing health care services pursuant to any federal waiver received by the state that waives any or all of the provisions pursuant to any other federal law adopted by amendment to the required Title XIX state plan." Based on this definition, all TennCare payments made to a licensed PLHSO such as Premier are included in the calculation of net worth and restricted deposit requirements.

2006 Net Statutory Net Worth Calculation

Tenn. Code Ann. § 56-32-212 states that the minimum net worth requirement shall be equal to the greater of (1) $1,500,000 or (2) an amount totaling 4% of the first $150,000,000 of revenue earned for the prior calendar year, plus 1.5% of the amounts earned in excess of $150,000,000 for the prior calendar year. Premier's premium revenue per documentation obtained from the TennCare Bureau totaled $223,617,997 for the calendar year 2005; therefore, Premier's minimum statutory net worth requirement based on 2005 revenue is $7,104,270. Premier reported total capital and surplus of $15,538,536 as of June 30, 2006, which is $8,434,266 in excess of the minimum net worth requirement.

Premium Revenue for the Examination Period

For the examination period the Premier contract included a risk banding agreement with the state. The BHO's risk is defined by the Medical Loss Ratio (MLR). Premier is at 100% risk for all medical expenses incurred that fall between and including 85% MLR and 91% MLR. For medical expenses in excess of 91% MLR, TennCare and Premier will each assume 50% of the Medical Expenses in excess of the 91% MLR. For medical expenses that fall below 85% MLR, TennCare and Premier each share 50% of the

medical expense savings. For the examination period January 1 through June 30, 2006, Premier's premium revenue as defined by Tenn. Code Ann. § 56-51-136 and § 56-32-212(a)(2) is:

TennCare Capitation	$ 110,578,423
Risk Share Revenue [1]	(2,723,790)
Total premium revenue January 1 through June 30, 2006	$107,854,633

[1] - Share of Premier earnings to be paid to TennCare.

2. Restricted Deposit

Tenn. Code Ann. § 56-51-136, § 56-32-212(b)(2) and § 56-32-212(b)(3) require all licensed PLHSOs to maintain a deposit equal to $900,000, plus an additional $100,000 for each $10 million or fraction thereof of annual premium revenue in excess of $20 million and less than $100 million as reported on the most recent annual financial statement filed with TDCI, plus $50,000 for each $10 million or fraction thereof of annual premium revenue in excess of $100 million. As previously noted, Tenn. Code Ann. § 56-32-212(a)(2) includes in the definition of premium revenue "any and all payments made by the state to any entity providing health care services pursuant to any federal waiver received by the state that waives any or all of the provisions pursuant to any other federal law adopted by amendment to the required Title XIX state plan."

Based upon premium revenues for calendar year 2005 totaling $223,617,997, Premier's statutory deposit requirement at December 31, 2005, is $2,350,000. Premier has on file with TDCI the necessary safekeeping receipts documenting that securities totaling $3,320,000 have been pledged for the protection of the enrollees in the State of Tennessee.

3. Management Agreement and Administrative Expense Allocations

Premier contracts with AdvoCare of Tennessee, Inc. (AdvoCare), a wholly-owned subsidiary of Magellan Health Services, Inc., to manage the operations, to provide administrative services and clinical services related to the provision of all mental health benefits, to provide case management services and to arrange primary care and outpatient

mental health services. AdvoCare contracts with outpatient mental health service providers directly on behalf of both Premier and TBH. AdvoCare reimburses outpatient mental health service providers utilizing payment methodologies including case rates, based primarily on level of services provided and the number of service encounters of such services. The cost of these services is allocated by AdvoCare to Premier and TBH using methods AdvoCare considered reasonable and that reflected utilization of services provided to Premier members. These methods include proportionate formulas based on monthly membership counts of both BHOs and other encounter data.

For NAIC financial statement reporting, the management fee must be apportioned to the administrative expense categories defined on NAIC annual and quarterly financial statements. The NAIC Health Quarterly and Annual Statement Instructions require that the reporting entity that has paid management fees to an affiliated entity "shall allocate these costs to the appropriate expense classification item (salaries, rent, postage, etc.) as if these costs had been born directly by the company…The reporting entity may estimate these expense allocations based on a formula or other reasonable basis."

The NAIC's Statement of Statutory Accounting Principles No. 70 requires where entities operate within a group where personnel and facilities are shared, the shared expenses should be apportioned to the entities incurring the expense as if the expense had been paid solely by the incurring entity.

Premier changed the allocation methodology since the last examination period. Magellan first allocates Premier's direct expenses to Premier. The remaining shared cost is allocated based on an appropriate formula in conformity with Statutory Accounting Principle No. 70.

4. Claims Payable

As part of the NAIC Statement filing requirements, Premier is required to provide a statement of actuarial opinion. This statement expresses an opinion on whether the claims payable reported by the BHO is adequate to cover all future obligations. This statement must be prepared by a member of the American Academy of Actuaries. Premier's statement was prepared by Ernst & Young, LLP, and met all the requirements established by the NAIC. The actuarial statement supported a claims payable amount of $29,895,244 as of June 30,

2006. This amount agreed with the amount reported on the NAIC balance sheet as "Claims Unpaid."

5. Third Party Liability Recoveries

Section 3.15.7 of the Provider Risk Agreement states third party liability recoveries will be treated as offsets to claims expense. Premier makes the adjustment for the recovered amount to the actual claim involved in the recovery. The amount is recorded as a reduction of medical expense.

B. Medical Loss Ratio

Effective June 7, 2001, the Provider Risk Agreement requires Premier to submit a MLR report monthly. The MLR accounts for medical payments and incurred but not reported (IBNR) claims expense based upon month of service. Premier submitted monthly MLR reports which reported actual and estimated monthly medical claims expenditures to be reimbursed by the TennCare Bureau. The estimated monthly expenditures are supported by a letter from an actuary which indicates that the MLR estimates for IBNR expenses have been reviewed for accuracy.

The Medical Loss Ratio reported for the period January 1 through June 30, 2006 is 80.3%. Including prior period adjustments, $2,723,790 risk share revenue due to the state was accrued for the period January 1 through June 30, 2006. No discrepancies were noted during the review of documentation supporting the amounts reported on the MLR reports.

C. Schedule of Examination Adjustments to Capital and Surplus

There are no adjustments to capital and surplus as a result of the examination.

VII. DETAIL OF TESTS CONDUCTED – CLAIMS PROCESSING SYSTEM

A. Time Study of Claims Processing

The purpose of conducting a time study of claims is to determine whether Premier pays claims promptly within the time frames set forth in Tenn. Code Ann. § 56-32-226(b)(1), and section 3.13.2 of the Provider Risk Agreement. The statute mandates the following prompt pay requirements:

> The health maintenance organization shall ensure that ninety percent (90%) of claims for payment for services delivered to a TennCare enrollee (for which no further written information or substantiation is required in order to make payment) are paid within thirty (30) calendar days of the receipt of such claims. The health maintenance organization shall process, and if appropriate pay, within sixty (60) calendar days ninety-nine point five percent (99.5%) of all provider claims for services delivered to an enrollee in the TennCare program.
>
> > (A) "Pay" means that the health maintenance organization shall either send the provider cash or cash equivalent in full satisfaction of the allowed portion of the claim, or give the provider a credit against any outstanding balance owed by that provider to the health maintenance organization.
> >
> > (B) "Process" means the health maintenance organization must send the provider a written or electronic remittance advice or other appropriate written or electronic notice evidencing either that the claim had been paid or informing the provider that a claim has been either partially or totally "denied" and specify all known reason for denial. If a claim is partially or totally denied on the basis that the provider did not submit any required information or documentation with the claim, then the remittance advice or other appropriate written or electronic notice must specifically identify all such information and documentation.

TDCI currently determines compliance with the prompt pay requirements of Tenn. Code Ann. § 56-32-226 by testing in three-month increments quarterly data file submissions from each TennCare regulated entity. Each month is tested in its entirety for compliance with the statutory prompt pay requirement. If a TennCare regulated entity fails to meet the prompt pay standards in any of the three months tested, TDCI, at a minimum, requires claims data submissions on a monthly basis for the next three months to ensure the regulated entity remains compliant.

The prompt pay testing results for the examination period and the most current submission since the examination period are as follows:

	Clean Claims Within 30 days	**All Claims Within 60 days**	**Compliance**
T.C.A. Requirement	90%	99.5%	
January 2006	100%	100.0%	YES
February 2006	100%	99.9%	YES
March 2006	100%	100.0%	YES
April 2006	100%	100.0%	YES
May 2006	100%	100.0%	YES
June 2006	100%	100.0%	YES
July 2006	100%	100.0%	YES
August 2006	100%	100.0%	YES
September 2006	100%	100.0%	YES
October 2006	100%	100.0%	YES

Premier processed claims timely in accordance with Tenn. Code Ann. § 56-32-226(b)(1) for claims processing requirements in the months of January 2006 through October 2006.

B. Determination of the Extent of Test Work of the Claims Processing System

Several factors were considered in the determination of the extent of test work to be performed in the testing of Premier's claims processing system.

The following items were reviewed to determine the risk that Premier had not properly processed claims:

- Complaints on file with TDCI related to accurate claims processing
- Results of prompt pay testing by TDCI
- Results reported on the claims payment accuracy report submitted to TDCI and TDMHDD
- Review of the preparation of the claims payment accuracy report
- Review of internal controls

There were no significant weaknesses noted; therefore, substantive tests were not increased.

C. Claims Payment Accuracy Report

The Provider Risk Agreement, Attachment E, Performance Measures and Liquidated Damages requires that performance measurements be submitted to TDMHDD in accordance with specifics outlined in the attachment. Specifically, Attachment E section I.2 requires that 97% of claims are paid accurately upon initial submission. Premier is required to submit quarterly a claims payment accuracy report 30 days following the end of each quarter.

Premier reported the following results for the examination period:

	Results Reported	Compliance
First Quarter 2006	99.83%	Yes
Second Quarter 2006	99.93%	Yes

1. Procedures to Review Claims Payment Accuracy Reporting

The review of the claims payment accuracy report included an interview with responsible staff to determine the policies, procedures, and sampling methodologies surrounding the preparation of the claims payment accuracy report. These interviews were followed by a review of the supporting documentation used to prepare the monthly reports for January through June 2006.

Evaluation of the test performed by Magellan indicates that a 2% randomized sample of completed claims processed by both the claims processing subcontractor, ACS, and the CMHC case rate payment system, are selected for audit. A detailed matrix of the audit database attributes tested was also reviewed.

2. Results of Review of the Claims Payment Accuracy Reporting

The number of claims tested and the methodology used to test the fee-for-service and the CMCH case rate claims are adequate.

D. Claims Selected For Testing

Sixty claims were selected for testing from the February, March, and April prompt pay data files submitted to TDCI in May 2006. For each claim processed, the data file included the date received, date paid, the amount paid and, if applicable, an explanation for denial of payment.

The number of claims selected for testing was not determined statistically. The results of testing are not intended to represent the percentage of compliance or non-compliance within the total population of claims.

To ensure that the February, March, and April 2006 data files included all claims processed for each month, the total amount paid per the data files was reconciled to the triangle lags. As part of the examination, the triangle lags were reconciled to the general ledger for the six month period to within an acceptable level.

The 60 claims selected for testing were fee-for-service claims processed through the ACS claims processing system. The CMHC case rate claims are designated as capitated claims in the data file and were not processed in the ACS system.

In lieu of performing attribute testing on the CMHC claims, two CMHCs were selected and the data for one month was examined for adjudication accuracy and compared to the prompt pay file and to encounter data submitted to TennCare Bureau.

Ten enrollees were selected from each CMHC and the encounters/claims for these enrollees were examined. No deficiencies were noted during the test work of CMHC claims.

E. Comparison of Actual Claim with System Claim Data

The purpose of this test is to ensure that the information submitted on the claim was entered correctly in the claims processing system. Attachment D of the Provider Risk Agreement lists the minimum required data elements to be captured from claims and reported to TennCare as encounter data.

Original hard copy claims were requested for the 60 fee-for-service claims selected for testing from the ACS claims processing system. If the claim was submitted electronically, the original electronic submission file associated with the claim was requested and reviewed. The data elements of Attachment D recorded on the claims selected were compared to the data elements entered into Premier's claims processing system.

Additionally, for the 10 enrollees selected from the CMHC system, claim information submitted by the CMHC to the BHO was compared with the encounter data reported to TennCare.

No discrepancies were noted.

F. Adjudication Accuracy Testing

The purpose of adjudication accuracy testing is to determine if claims selected were properly paid, denied, or rejected.

No discrepancies were noted.

G. Price Accuracy Testing

The purpose of price accuracy testing is to determine whether payments for specific procedures are in accordance with the system price rules assigned to providers, whether payments are in accordance with provider contracts, and whether amounts are calculated correctly.

No discrepancies were noted.

H. Copayment Testing

The purpose of testing copayments is to determine if the copayments for enrollees subject to out-of-pocket payments for certain procedures are accurately calculated in accordance with section 3.4.4 of the Provider Risk Agreement.

TDCI requested a list of the 100 enrollees with the highest dollar amount of copayments applied. The copayment amounts for five Premier enrollees were compared to the copayment information in the ACS (fee-for-service) claims processing system.

No discrepancies were noted.

I. Remittance Advice Testing

The purpose of remittance advice testing is to determine whether remittance advices sent to the provider accurately reflect the processed claim information in the system.

The remittance advices for eleven of the fee-for-service claims selected for testing were obtained to compare the payment and/or denial reasons per the claims processing system to the information communicated to the providers. No differences were noted between payment information in the claims processing system and the information communicated to the providers.

J. Analysis of Cancelled Checks

The purpose of analyzing cancelled checks is to verify the actual payment of claims by Premier and determine whether a pattern of significant lag times exists between the issue date and the cleared date on the checks examined.

The cancelled checks for the five claims tested were requested. The check amounts agreed with the amounts paid per the remittance advices and no pattern of significant lag times between the issue date and the cleared date was noted.

K. Pended Claims

The purpose of testing pended claims is to determine the existence of claims that have been suspended or pended by Premier, the reasons for suspending the claims, the number of suspended claims that are over 60 days old, and whether a potential material unrecorded liability exists. Premier provided the examiners a pended claims report as of October 31, 2006. Premier reported a total of 7,222 pended claims of which 5,886 were over 60 days old. TDCI required Premier to provide an explanation for the material number of claims over 60 days in the pended and unpaid data file. Premier provided the following acceptable explanation: "The… increase in the pended claims volume is due to an adjustment project that was underway at the end of the month of September. This project was generated as a result of the State mandated rate increase of 2.5%. Although the rate was effective 1/1/06, the claims could not be adjusted until September due to provider communication and system update requirements. Claims were finalized on the first check cycle in October." The review of the pend file does not indicate a potential material unrecorded liability exists.

L. Electronic Claims Capability

Section 3.13.2 of the Provider Risk Agreement states, "The Contractor shall have in place, an automated claims processing system capable of accepting and processing claims submitted electronically." The electronic billing of claims allows the BHO to process claims more efficiently and cost effectively.

The Health Insurance Portability and Accountability Act, Title II ("HIPAA") required that all health plans be able to transmit and accept all electronic transactions in compliance with certain standards as explained in the statute by October 15, 2002. The U.S. Department of Health and Human Services extended the deadline until October 15, 2003, for health plans requesting

additional time. Failure to comply with the standards defined for the transactions listed can result in the assessment of substantial penalties.

Premier has implemented the necessary changes to process claims per the standards outlined in the HIPAA statutes. Premier is currently processing claims under these standards for some providers.

M. Mailroom Testing and Claims Inventory Controls

The purpose for the review of mailroom and claims inventory controls is to determine if procedures followed by Premier ensure that all claims received from providers are either returned to providers where appropriate or processed by the claims processing system. The review of the mailroom and claims inventory internal control questionnaire section provided assurance that mailroom inventory controls are adequate.

VIII. REPORT OF OTHER FINDINGS AND ANALYSES – COMPLIANCE TESTING

A. Provider Complaints

The purpose for testing provider complaints is to determine if Premier has developed adequate procedures to ensure provider complaints are responded to in a timely manner.
Premier's Provider Manual outlines the claims payment dispute and Magellan's Policies address members/customer inquiry and appeals process. The procedures require that Premier must respond to the inquirant in writing within 30 days.

The complaint log for the month of June was reviewed. Ten claims selected were tested. The provider complaints tested were all responded to within 30 days.

B. Provider Manual

The provider manual outlines written guidelines for providers that include, but are not limited to, requirements for obtaining authorization to provide certain treatments to enrollees and for submitting claims for payment. In addition, the provider manual informs providers of the correct procedures to follow in the event of a disputed claim.

Premier's provider agreements reference Premier's provider manual for written guidelines as it pertains to standards for care, utilization review/quality improvement, claims processing and other procedural requirements. These

references incorporate the provider manual into the provider agreements, and therefore the provider manual requires prior approval in accordance with Tenn. Code Ann. § 56-51-108.

Premier has submitted its provider manual to TDCI and has received approval.

C. Provider Agreements

Agreements between a PLHSO and medical providers represent operational documents to be prior approved by TDCI in order for TDCI to grant a certificate of authority for a company to operate as an PLHSO as provided by Tenn. Code Ann. § 56-51-106(6). A licensed PLHSO is required to file a notice and obtain the Commissioner's approval prior to any material modification of the operational documents in accordance with Tenn. Code Ann. § 56-51-108. Additionally, TDMHDD has defined through contract with Premier minimum language requirements to be contained in the agreements between Premier and its contracted providers. These minimum contract language requirements include, but are not limited to, standards of care, assurance of TennCare enrollees' rights, compliance with all Federal and State laws and regulations, and prompt and accurate claims payment.

Section 3.9.2 of the Provider Risk Agreement requires that all provider agreements executed by Premier shall at a minimum meet the current requirements listed in Section 3.9.2 of the Provider Risk Agreement.

Seven provider agreements related to claims selected for testing were reviewed to determine if they contained all the minimum language requirements of Section 3.9.2 of the Provider Risk Agreements. Six of the seven agreements met the minimum language requirements as of June 30, 2006.

One provider agreement contained material modifications related to payment methodology that had not been approved by TDCI prior to the execution of the agreement.

Management Comments

Management concurs.

The violation identified was specific to the amendment to Youth Villages' contract that added mobile crisis services for children and adolescents. This

was during the Children's Services Expansion Initiative in 2002/2003, which was closely monitored by and carried out under the direction of TDMHDD's OMC. While the amendment template utilized was a standard amendment template document on file with TDCI, due to the nature of the expansion project there was language that was added to the amendment that described the grant payment methodology to be employed by Magellan to reimburse the provider for the provision of the services. This language was descriptive of something that was not outside the ordinary when describing a grant payment methodology, but the language was not specifically on file as standard template language with TDCI. Due to the implications of this finding (which was shared during the onsite audit), Magellan initiated a meeting with TDCI to discuss the issue and has since been filing similar amendments to provider agreements with TDCI as potential material modifications while we compile a set of common amendment language scenarios (within the body of the standard template already on file) for approval.

D. Subcontracts

PLHSOs are required to file a notice and obtain the Commissioner's approval prior to any material modification of operational documents in accordance with Tenn. Code Ann. § 56-51-108 and the Provider Risk Agreement Section 3.9.

Premier contracted with Community Service Agencies to coordinate the delivery of transportation through a provider agreement. Community Service Agencies (CSA) are paid an administrative fee to schedule transportation services for Premier enrollees. Premier should have contracted with the CSAs through a subcontract versus a provider agreement.

On March 10, 2005, Premier submitted for approval a subcontract for transportation services. On April 6, 2005, TDCI disapproved the subcontract submission for missing language required by the Provider Risk Agreement. Revised subcontracts were never resubmitted to TDCI.

Premier should correct the deficiencies noted in the April 6, 2005, correspondence. This process should not be delayed in anticipation of a carve-out of transportation services by TennCare.

Management Comments

Management concurs. Management will submit the revised sub-contract documents to TDCI in an expedited manner.

E. Non-discrimination

Section 3.17 of the Provider Risk Agreement requires Premier to demonstrate compliance with Federal Title VI of the 1964 Civil Rights Act, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age of Discrimination Act of 1975 and the Omnibus Budget Reconciliation Act of 1981. Based on discussions with various Premier staff and review of policies and related supporting documentation, Premier was in compliance with the applicable sections of the Provider Risk Agreement.

F. Holding Companies

Tenn. Code Ann. § 56-51-151 states, "Each prepaid limited health service organization is subject to the provision of Title 56, Chapter 11." Tenn. Code Ann. § 56-11-205 states, "Every insurer and every health maintenance organization which is authorized to do business in this state and which is a member of an insurance holding company system or health maintenance organization holding company system shall register with the commissioner…." Premier has complied with this statute.

G. Internal Audit Function

The importance of an internal audit function is to provide an independent review and evaluation of the accuracy of financial recordkeeping, the reliability and integrity of information, the adequacy of internal controls, and compliance with applicable laws, policies, procedures, and regulations. An internal audit function is responsible for performing audits to ensure the economical and efficient use of resources by all departments to accomplish the objectives and goals for the operations of the department. The internal audit department should report directly to the board of directors so the department can maintain its independence and objectivity.

Magellan's internal audit function is primarily responsible for all testing related to the company's Sarbanes Oxley compliance. In addition, an audit plan is developed each year based on feedback from various internal and external parties. Magellan's Board of Directors reviews the audit plan. Magellan's Senior Vice-President of Internal Audit reports to the Audit Committee.

H. Conflict of Interest

Section 6.5 of the Provider Risk Agreement warrants that no part of the amount provided by TennCare shall be paid directly or indirectly to any officer or employee of the State of Tennessee as wages, compensation, or gifts in exchange for acting as an officer, agent, employee, subcontractor, or consultant to TBH in connection with any work contemplated or performed relative to this Agreement unless otherwise authorized by the Commissioner, Tennessee Department of Finance and Administration.

Conflict of interest requirements of the Provider Risk Agreement were expanded to require an annual filing certifying that the BHO is in compliance with all state and federal laws relating to conflicts of interest and lobbying.

Failure to comply with the provisions required by the Provider Risk Agreement shall result in liquidated damages in the amount of one hundred ten percent (110%) of the total amount of compensation that was paid inappropriately and may be considered a breach of the Provider Risk Agreement.

The BHO is responsible for maintaining adequate internal controls to detect and prevent conflicts of interest from occurring at all levels of the organization and for including the substance of Provider Risk Agreement conflict of interest clauses in all subcontracts, provider agreements, and any and all agreements that result from the Provider Risk Agreement.

Premier demonstrated the following efforts to ensure compliance with the conflict of interest clause of the Provider Risk Agreement:

- The organizational structure of Premier includes a compliance officer.
- Premier has written conflict of interest policies and procedures in place.
- The written policies and procedures outline steps to report violations.
- The policy indicates all business associates are to comply with Premier's conflict policy.

Employees complete conflict of interest certificates of compliance annually per the written policy and procedures.

The examiners hereby acknowledge the courtesy and cooperation of the officers and employees of Premier.